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July 21, 2026

Robert F. Kennedy, Jr., Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–2449–P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Secretary Kennedy and Dr. Oz:

The Massachusetts Health & Hospital Association (MHA), on behalf of its member hospitals and health systems, appreciates the opportunity to offer our perspective regarding the proposed changes to Medicaid Managed Care State Directed Payments (SDPs) and related rules issued by the Centers for Medicare & Medicaid Services (CMS) in the May 22, 2026 *Federal Register*. MHA members include 76 licensed Massachusetts hospitals, many of which are organized within health systems. MHA members represent the full spectrum of hospitals in Massachusetts, including safety net facilities, disproportionate share hospitals, academic medical centers, specialty hospitals, community hospitals, critical access hospitals, and long-term care hospitals. All participate in the MassHealth program, which serves approximately 1.9 million Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

MHA would like to acknowledge CMS's partnership with state Medicaid programs in financing the costs of medical assistance and the administration of state Medicaid plans, as well as soliciting and considering input from stakeholders, including those like MHA whose members are affected significantly by Medicaid financing issues. We appreciate the opportunity to provide comments on the proposed rule and reiterate our commitment to partnering to achieve patient-centric solutions to the pressures facing our healthcare system.

In the spirit of preserving that shared mission and in alignment with hospitals across the nation, our comments are intended to illustrate the enormous impacts of this proposal on healthcare access and the strength of the economy, while providing feedback on how to build a more sustainable path forward.

PRESERVING THE FEDERAL AND STATE MEDICAID PARTNERSHIP

At its core, the Medicaid program is a state and federal partnership focused on ensuring access to healthcare for millions of people. Since its creation, the Medicaid program has required states and the federal government to work collaboratively to develop health coverage offerings and financing arrangements that take into consideration the unique situations of a state's healthcare needs, the local providers that serve these patients, and the varying state resources to support the care. Flexibility has been a hallmark of the Medicaid program, which has led to significant reductions in the number of uninsured people and the meaningful transformation in how healthcare is financed and delivered.

MHA acknowledges CMS's obligation to ensure that the program is implemented with integrity and in a manner that complies with federal statute. At the same time, it is vital that CMS maintain a productive and flexible relationship with local governments and healthcare providers to allow the Medicaid program to continue to innovate and sustain its decades of proven successes. Medicaid SDPs are essential components of the financing that drives these payment and delivery system reforms, funds quality incentive programs, and ensures that access to services is sustainable. In turn, SDPs allow healthcare providers and the government to deliver on their shared goal of high-quality care for every patient.

If the proposed rule goes forward as drafted, states will be severely limited in accomplishing these goals. The proposed rule makes it nearly impossible to incorporate quality incentive programs in managed care or to direct Managed Care Organizations (MCOs) away from fee-for-service claims payment methodologies given the reliance of the proposed claims-based comparisons to Medicare reimbursement. The proposed rule also handcuffs states' ability to support access to critical services, including primary care and behavioral health, and to ensure safety net, pediatric, and cancer hospitals receive payment adjustments unique to their populations. States will lose their ability to innovate in the Medicaid program and to ensure healthcare services at the local level are protected as they will be forced to either forfeit innovative payment arrangements or force-fit them into a rigid, one-size-fits-all mathematical computation based on Medicare. **This proposed approach translates into an effective federalization of Medicaid reimbursement for healthcare services and devalues state flexibility and local management of scarce healthcare resources**. **If the proposed rule moves forward as drafted, it will ultimately create federal overreach into local healthcare decision-making in a way that is administratively burdensome, runs counter to the administration's stated goals, and financially damaging to states, healthcare providers, and ultimately patients.**

CURRENT FINANCIAL STATE OF HEALTH SYSTEMS & FUTURE OUTLOOK

The Massachusetts healthcare system finds itself in an already fragile financial state, with hospitals running in the red or on razor-thin margins. In FY2024, the state's Center for Health Information and Analysis (CHIA) found that 61% of Massachusetts acute care hospitals reported negative operating margins, resulting in a statewide median operating margin of negative -2%.[1] Factoring in hospital affiliated physician groups, 74% of hospital health systems reported negative operating margins with these systems losing $1.4 billion collectively on operations in FY2024. These trends continued into FY2025 and

[1] https://www.chiamass.gov/insights-analysis/provider-financial-data/hospital-and-hospital-health-system-annual-performance

FY2026. Many health systems have been forced to make difficult decisions that affect their workforce, services, and investments in their facilities.

Unfortunately, the future outlook is even more grim. Hospitals and health systems are now bracing for the effects of significant reductions in Medicaid and subsidized insurance coverage due to federal changes required by the "Working Families Tax Cut" (WFTC) legislation that are anticipated to result in 300,000 residents in Massachusetts losing health insurance coverage. In turn, this will substantially increase hospital uncompensated care delivered to newly uninsured residents and cause overcrowding in hospital emergency departments for all patients. Safety net providers are also facing significant challenges related to the 340B Drug Pricing Program, which threaten to divert to pharmaceutical manufacturers key hospital financial resources that are currently needed to support care delivery.

MHA respectfully implores CMS to recognize the confluence of these threats, including the proposed SDP rule, that will create an untenable fiscal environment for healthcare providers and will undoubtedly mean a reduction in access to medically necessary services for all patients – regardless of their insurance coverage. Reductions of this magnitude could very well result in the closure of hospitals, especially those that care for disproportionate numbers of Medicaid patients.

Not only will this rule damage hospital health systems and the Medicaid program's ability to innovate and serve low-income patients, but **the magnitude of the funding losses would extend to the overall economy.** Healthcare organizations are a leading driver of the economy, contributing significantly to gross domestic product and employment. Hospitals are the largest component of that healthcare sector, employing individuals that exhibit the highest professionalism, skill, and dedication to the business of improving and saving lives. Massachusetts hospitals employ approximately 207,000 people and, through the ripple effect in the economy, contribute to more than 450,000 jobs in the commonwealth.

Hospitals are anchors for their communities; they are always there, always open, always accessible, and they provide an irreplaceable measure of stability to people as they go about their lives. As they prosper, so does their influence. If they close or are forced to cut service lines, regional economies, workers, and patients all suffer. Healthcare providers that rely heavily on Medicaid financing already have undergone cost-cutting measures to remain financially viable, and any further cutbacks would likely affect their ability to continue employment and services at current levels. The bottom-line effect of the proposed SDP rule will undoubtedly result in significant reductions in access and provision of medical services, harming local communities and economies.

WITHDRAW PROVISIONS THAT GO BEYOND CONGRESSIONAL MANDATE

MHA's comments are intended to provide CMS with important perspective regarding (1) the proposed provider-specific, Medicare claims-based comparison for evaluating SDPs in contrast to long-standing measurement of these payments in the aggregate at the provider class level; (2) the proposed prohibition for states to direct Medicaid uniform rate increases to address payment inadequacies and target reimbursement improvements to safety net providers; and (3) the devastating impact of the proposed rule on hospitals, safety net providers and, in turn, patients, healthcare systems, and local and national economies.

MHA particularly is opposed to the proposed rules that go beyond the required changes of the WFTC legislation, resulting in federal savings of $510 billion from 2026 through 2035 – $360 billion more than budgeted by the Congressional Budget Office (CBO) for the new statutory limits on SDPs. Numerous provisions that CMS has opted to include contribute to the fact that the proposed rule exceeds Congressional savings expectations by 240%.

If this proposed rule proceeds, the financial impact will be greatly damaging to Medicaid and CHIP programs, state budgets, and healthcare systems and will culminate in the reduction of patient access and services for all patients – including beyond Medicaid beneficiaries. **For the many reasons put forward above and as further articulated below, MHA joins states across the nation in respectfully requesting that CMS withdraw the majority of this proposed rule, including the numerous proposals that extend beyond the statutory framework established by Congress. With Congress, we also implore CMS to revisit the application of statutory Medicare payment limits for these essential supplemental payments.**

Specifically, we respectfully ask that CMS:

- Remove the claims-based aspect of the Medicare equivalent comparison and revert to the long-standing method of comparing SDPs in the aggregate at the provider class level;
- Modify its position and exempt all quality incentive payments from the Medicare payment equivalent comparison;
- Withdraw the proposal to prohibit uniform rate increases;
- Withdraw the proposal to align the proposed SDP limitations for practitioner payments under Medicaid fee-for-service;
- Maintain the proposed time-limited exemption for separate payment terms and retrospective changes to preprint submissions; and
- Continue to permit states to define their provider classes in alignment with their state Medicaid plans.

PROPOSED CLAIM SPECIFIC MEDICARE PAYMENT EQUIVALENT LIMIT

A. MEDICARE PAYMENT LEVELS

Under the WFTC legislation, SDPs are now required to be limited at 100% of the published Medicare payment rate (where available) for Medicaid expansion states such as Massachusetts. This new limit applies to non-grandfathered SDPs.

While we recognize that CMS is charged with implementing the new law that requires a Medicare benchmark, we maintain our concerns with using Medicare as the payment limit for SDPs. Compared to the current Average Commercial Rate (ACR) ceiling, this lower limit will be financially destabilizing and will have damaging ramifications on healthcare providers that will affect their ability to provide services to Medicaid patients, potentially threatening the very viability of some providers. This in turn will have devastating consequences on access to healthcare services for Medicaid patients.

Based on MHA's review of Medicare reimbursement rates, Medicare fee-for-service rates do not on average cover the cost of providing care to Medicare patients. For outpatient services, the Medicare fee-for-service rates significantly fall short, with aggregate reimbursement levels estimated to only cover approximately 85% of the cost of providing care to Medicare patients.

In contrast, commercial payers do not typically reimburse services below the cost of providing care – otherwise providers would not agree to contract with such companies. Unfortunately, providers do not have that leverage with Medicare. For this reason, MHA has supported using commercial rates as the limit for Medicaid managed care SDPs. Prior to this proposed rule, CMS cited commercial rates as an appropriate benchmark given the need for Medicaid managed care plans to compete with commercial plans for providers in the networks.[2] Recognizing the WFTC's current mandate, MHA looks forward to revisiting the Medicare payment level for SDPs in the near future with both CMS and Congress.

B. DEVIATION FROM PROVIDER CLASS PAYMENT LIMITS

The proposed application of the Medicare payment equivalent at the provider-specific, claim-specific level will eliminate state Medicaid program flexibility to target supplemental payment to safety net providers, resulting in a significant reduction in resources for these healthcare providers.

Prior to this proposed rule, a Medicare payment equivalent did exist in the Medicaid program for Medicaid State Plan supplemental payments. While this method incorporates the Medicare underpayment level into the ceiling, a key difference between this method and the proposed Medicaid SDP Medicare payment limit is the application of it. Under Medicaid State Plan supplemental payments, the Upper Payment Limit (UPL) methodology allows for the *collective differential* of hospitals to be accumulated to determine available room for additional payments within the provider class. Prior to the proposed Medicaid SDP rule, SDPs were also measured in the aggregate at the provider class level.

Using this aggregate provider class method provides states with flexibility to design supplemental payments that target payments to key Medicaid providers such as disproportionate share hospitals, pediatric hospitals, public hospitals, and cancer hospitals in ways that are not constrained by Medicare claims-level reimbursement methodologies that both (1) underpay relative to cost and (2) do not entirely align with Medicaid reimbursement and the resources needed to support care provided to Medicaid patients.

For these reasons and because the claim specific process is not mandated by the WFTC legislation, MHA respectfully requests CMS remove the claims-based aspect of the Medicare equivalent comparison and revert to the long-standing method of comparing SDPs in the aggregate at the provider class level.

C. COMPLICATIONS WITH QUALITY INCENTIVE PAYMENTS

CMS proposes that SDP Value Based Payments (VBPs) be added to the Medicaid claims-based reimbursement payments to be compared to the Medicare equivalent claims-based payment. States would need to compute updated Medicare payment equivalents by including the quality incentives that are determined well after the claims-based payments have been paid. States would also be challenged with

[2] FR 88, May 3, 2023, p.28122

then retrospectively allocating quality incentive payments on a claim-by-claim basis. The risk of not earning the incentive funding for reasons other than performance will increase substantially, resulting in providers no longer supporting such incentive programs and states abandoning these incentives in managed care.

To achieve improved patient outcomes and succeed in frequently changing quality measures, hospitals devote significant resources to operationalizing evidence-based protocols, designing and implementing new clinical interventions, strengthening data reporting and analysis, and improving the patient experience. The entire hospital and health system is involved as they align clinical practices, data infrastructure, and organizational culture involving the full care delivery team, as well as dedicated teams focused on quality measurement, hospital leadership, IT, and support staff. The investment to improve and meet quality expectations is financially significant and hospital staff take pride in dedicating immense effort, care, and prioritization toward these goals.

Hospitals are already taking on significant risk for earning these incentive payments based on their performance as well as nuances of the measurement methodologies. Given the enormous efforts and resources they dedicate toward these goals, hospitals are often left weakened when they do not earn incentive funding due to factors that are outside their control. **The proposed claim-by-claim Medicare equivalent limitation would substantially increase hospitals' risk of not earning quality incentive dollars for reasons unrelated to clinical performance, which would harm their ability to make further investments in quality improvement work, demoralize staff charged with meeting these goals, and ultimately limit the resources available to patients.**

The proposal to allocate quality incentive payments retrospectively on a claim-by-claim basis is also questionable and impractical. Quality payments are typically paid up to two years after the time when claims for the relevant year already have been paid. Given the data is based on patient care delivered, a complete performance year's data is typically only available a year later. Further time is then needed by the state to analyze the data, benchmark across other hospitals, and calculate payments. The entire process typically takes up to two years.

Hospital quality incentive payments are designed to reimburse above and beyond the standard claims payment and are considered a reward for performance and improvement in patient care outcomes. The quality incentive payments are not necessarily calculated in a way that aligns with standard distribution across all inpatient discharges and outpatient visits. To meet the proposed rule requirements, states will be required to force-fit these quality payments into a claims-based method using some distribution methodology.

We believe the treatment of quality incentives as claims-based reimbursement is highly inappropriate and ultimately defeats the very purpose of value-based payments to incentivize change. For these many reasons, MHA strongly opposes the application of a claim-specific Medicare payment equivalent for quality incentive SDP payments. We respectfully request CMS modify its position and exempt all quality incentive payments from the Medicare payment equivalent comparison.

D. INCREASED ADMINISTRATIVE BURDEN & COMPLEXITY

MHA believes the claim-specific requirement is an unwarranted administrative burden on states and healthcare providers at a time where both – in alignment with the administration – are focused on simplifying the healthcare system reducing administrative expenses to improve affordability.

To comply with SDP Medicare payment equivalents at the claim level, states and hospitals will be forced to significantly increase administrative processes and expenses. In Massachusetts, more than 2.5 million inpatient and outpatient hospital claims are billed to Medicaid Managed Care Entities (MCEs). Under this rule, each one of these claims would require processes to determine the level of SDPs that could fit on each claim and meet the proposed CMS requirements.

Medicaid hospital claims-based reimbursement is complex, with reimbursements rates varying for each of the more than 1,300 inpatient All Payer Refined Diagnosis Related Groups (APR-DRGs) and more than 660 outpatient Enhanced Ambulatory Payment Groups (EAPGs). Reimbursement is further varied for each claim by hospital wage areas, outliers, and other adjustments for cancer, pediatric, and safety net hospitals. It will be highly burdensome and potentially unmanageable to design SDP supplemental payment methodologies that align effectively with thousands of different Medicare payment equivalents at the claim level.

For these reasons and because the claim-specific process is not mandated by the WFTC legislation, MHA respectfully requests CMS remove the claims-based aspect of the Medicare equivalent comparison and revert to the long-standing method of comparing SDPs in the aggregate at the provider class level. This alternative meets the requirements of the law and does not expose states to substantial administrative burdens and unmanageable complexities.

PROPOSED PROHIBITION ON UNIFORM RATE INCREASES

Beginning January 1, 2028, CMS proposes to remove states' ability to create SDPs that rely on a uniform dollar or percentage increase. This provision will apply only to new SDPs and renewals of non-grandfathered SDPs that utilize uniform increases. **MHA respectfully requests that CMS withdraw this proposal because this SDP is an essential method of directing payments to support critical services and providers, and this limitation is not required in the WFTC legislation.** MHA assumes that the proposed prohibition on "uniform rate increases" is one of the key reasons why the estimated spending reductions are 3.4 times greater than CBO estimates.

Massachusetts currently uses "uniform rate increases" to enhance reimbursement above the base APR-DRG and EAPG methodologies. In an ideal world, supplemental payments would not be needed if state Medicaid reimbursement rates covered the cost of providing care to patients. This is unfortunately not the reality, including in Massachusetts where hospital fee-for-service rates reimburse well below the cost of care. With limited resources, supplemental payments are an essential financing approach to ensuring that healthcare providers, including safety net, disproportionate share, and pediatric hospitals, receive added support for the care they provide to Medicaid patients. Supplemental payments, including those financed by SDP "uniform rate increases," help to ensure that access to comprehensive healthcare for low-income people is maintained in communities where large numbers of Medicaid patients live and seek care.

Removing the ability to make "uniform rate increases" for new SDPs and SDPs either non-grandfathered or past their grandfathering period will require significant structural changes to rate increases now tied to days, discharges, or claim counts. While states could attempt to repurpose these payments into the APR-DRG and EAPG methodologies, this will have unknown and highly variable negative consequences to specific providers, including community hospitals serving disproportionate numbers of Medicaid patients. Medicaid MCOs will also be exposed to greater financial risk if their fee schedules are substantially restructured under this alternative approach. We believe if the proposed rule goes forward to eliminate "uniform rate increases," states will not be able to effectively enhance payments through SDPs to key healthcare providers and services. Ultimately, this will have a significant financial impact on safety net providers, especially smaller hospitals, jeopardizing their ability to sustain services.

Because the proposal to eliminate "uniform rate increases" (1) substantially reduces state flexibility to target enhanced payments to key providers and services, (2) increases administrative burden and restructuring of Medicaid reimbursement methodologies, and (3) is not required by federal law, MHA respectfully requests CMS withdraw this provision.

TARGETED PAYMENT LIMITS IN MEDICAID FEE-FOR-SERVICE

CMS proposes to align limitations of practitioner payments under Medicaid fee-for-service with the new limitations on SDPs, including claim-specific Medicare equivalents. If a state makes payments to a subset of targeted practitioners, the new proposed limit would be actual Medicare payment rates applicable to the practitioner or provider.

For all the reasons described above for hospitals, claim-specific Medicare payment equivalent comparisons will be highly complex and impractical to implement given the need to compare Medicaid physician reimbursement with Medicare reimbursement methods. In Massachusetts, for instance, the majority of primary care physicians are reimbursed not on a claim-by-claim basis, but instead are paid on a capitated basis in the innovative MassHealth Accountable Care Organization (ACO) program. It would be impractical to reconcile these very different Medicare and Medicaid payment methods. Similar to the issues raised regarding quality incentive payments, physician incentive payments would be complicated by attempting to compare to a Medicare claim-based reimbursement benchmark. **For these reasons and because this provision is not required by the WFTC legislation, MHA respectfully requests CMS withdraw the proposal to align the proposed SDP limitations for practitioner payments under Medicaid fee-for-service.**

SEPARATE PAYMENT TERMS

CMS proposes a time-limited exemption to the prohibition on separate payment terms and retrospective changes to preprint submissions. This pause would continue until existing SDPs are no longer considered grandfathered. Grandfathered programs that use separate payment terms or make retrospective adjustments would be able to maintain that structure until payment levels phase down to the new Medicare limit, rather than needing to redesign the programs beginning in 2027. **MHA supports this proposal as it preserves state flexibility and mitigates some of the destabilizing financial ramifications of the rule**. MHA also requests CMS consider going further and making the exemption permanent given the significant levels of reporting transparency, new monitoring against payment limits, as well as the provision is not required by Congressional action.

PROVIDER CLASSES

CMS does not propose additional limitations on how states define provider classes within the preprint, however it requested comment as to whether new limitations should apply. **MHA respectfully requests CMS continue to permit states to define their provider classes using methodologies and definitions that must be approved by CMS.** Removing flexibility for states to define their provider classes in ways that, for example, do not align with groups of providers defined in the Medicaid state plan, would significantly limit a state's ability to target certain groups of providers in need of enhanced payments to preserve access to care.

CONCLUDING COMMENTS

In summary, the proposed Medicaid SDP rule would run counter to our shared goals of strengthening care access and economic wellbeing. It will result in catastrophic changes in Medicaid programs across the country if adopted. The ultimate effect of the rule's complexity, limitations on state Medicaid programs, and administrative burdens will be a significant loss of federal support for care provided to Medicaid enrollees. States and, in turn, hospitals will have little choice but to make drastic decisions that will negatively affect enrollee access to care. The viability of some hospitals will come into question and progress in innovating Medicaid programs such as our state's ACO program will suffer.

As CMS finalizes these regulations, we respectfully request CMS take into consideration the tremendous financial challenges healthcare providers face as well as the significant role the Medicaid program has in ensuring a viable, thriving healthcare system that can continue to provide accessible and high-quality services for all patients. MHA strives to be constructive in all aspects of policy making, both here in Massachusetts and with our federal partners. While we understand CMS has an obligation to ensure program integrity, in our opinion this proposed rule is too drastic in nature and is impossibly impractical to implement in a reasonable manner. Further, the proposal goes well beyond the SDP limitations called for by Congress and in federal statute.

For the many reasons articulated in this letter, MHA respectfully requests that the majority of provisions in the proposed rule be withdrawn. We appreciate your consideration of our comments and would welcome the opportunity to further engage with CMS on this issue.

Sincerely,

Steve Walsh
President and CEO
Massachusetts Health & Hospital Association